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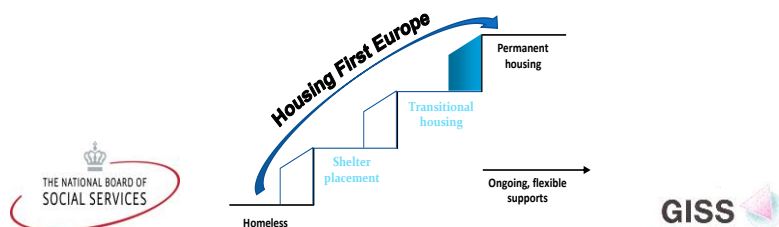
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Housing First Europe Local Evaluation Report Glasgow

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Sarah Johnsen with Suzanne Fitzpatrick



Supported by the European Union Programme for Employment and Social Security – PROGRESS (2007-2013)



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Glasgow Housing First

Final Report for the Housing First Europe Project

Sarah Johnsen with Suzanne Fitzpatrick

May 2013

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1. Introduction

1.1 Background to the pilot

The Housing First project in Glasgow is a three-year pilot providing housing and support to 22 individuals who are homeless and actively involved in substance misuse. The pilot began in October 2010 and will run until September 2013.

The project is operated by Turning Point Scotland (TPS), a charitable organisation providing a range of support services for adults with complex needs in Scotland. Turning Point Scotland (TPS) is the first provider to implement a Housing First approach in the UK (Johnsen and Teixeira, 2010).

The pilot was developed after a scoping exercise, conducted in Glasgow by TPS in 2009, which revealed high levels of repeat homelessness amongst homeless drug users and identified a number of barriers faced by this client group when accessing services. It was thus developed with a view to reducing recurrent homelessness by accommodating and supporting individuals who are in active addiction.

The Glasgow Housing First project is funded by TPS, the Big Lottery Fund, and Greater Glasgow and Clyde Health Board.

1.2 The evaluation

The Housing First pilot is being independently evaluated by Dr Sarah Johnsen and Prof Suzanne Fitzpatrick, researchers at Heriot-Watt University. The evaluation has been funded by TPS and will run for the full duration of the pilot (i.e. October 2010 to September 2013).

The evaluation aims to assess the effectiveness of the project in achieving the intended outcomes for service users, including (amongst others): improvement in personal living situation; reduction or no increase in substance misuse; improved physical health and psychological wellbeing; reduction in criminal activity; and improved capacity to participate in and be valued by society (see Chapter 2 for full details).

The evaluation is longitudinal and involves three main methods:

1. *Interviews with TPS staff and representatives of key stakeholder agencies.* These are being conducted on two occasions: initially when the pilot had become fully operational and 'bedded down' in order to explore views on the process of setting up the project (wave one); and again toward the end of the pilot period to explore staff and stakeholder assessments of the project's strengths, weaknesses and overall effectiveness (wave two).
2. *Interviews with pilot service users.* These will also be conducted twice: initially after being recruited to the project to gather baseline data about participants' characteristics, support needs and aspirations (wave one), and again one year later to examine specific pilot outcomes and the overall impact that the project has had on their lives (wave two). Provisions have been made for follow-up interviews with service users should they exit the programme prior to the end of the pilot period.

3. *Case file analysis.* All service users have granted the research team permission to access the contents of their case files, held by TPS. These contain records of support needs, services received, and issues raised during quarterly review meetings. Service users' case file records will be analysed toward the end of the evaluation period.

The pilot and evaluation are still ongoing, thus this report draws upon data from:

- Wave one (completed). This included the initial interviews with staff and stakeholders (held between June and December 2011), and 'baseline' interviews with service users (held between February 2011 and October 2012). A total of four frontline staff members were interviewed in this wave, as were nine stakeholders, and 21 (of the total 22) service users.
- Wave two (in progress). To date, wave two interviews have been conducted with a senior member of the staff team, 11 stakeholders, and 13 (of the 21) service users participating in the evaluation. Wave two interviews with the remaining service users, as well as all frontline staff, will be conducted toward the end of the pilot period, as will the case file analysis.

Given that data collection and analysis for wave two service user and stakeholder interviews are incomplete, and the wave two frontline staff interviews and case file analysis have not yet begun, preliminary conclusions regarding project outcomes must necessarily be regarded as tentative. All statistics provided were correct as at January 2013. Full details regarding project outcomes will be made available at the conclusion of the evaluation in autumn 2013.

The evaluation design does not allow for the analysis of project costs or cost effectiveness.

1.3 Report outline

This report comprises seven chapters. The next, Chapter 2, provides an overview of the pilot's operational features and context. Chapter 3 profiles the service users' demographic characteristics and support needs at the point of their recruitment to the project. Chapter 4 provides details regarding the support received by service users from the pilot and other mainstream services, together with an assessment of their satisfaction with the support provided. Chapter 5 outlines key preliminary findings regarding service user outcomes, insofar as data allows at this point in the evaluation. This is followed, in Chapter 6, by a review of the lessons learned and operational challenges encountered to date. The report concludes in Chapter 7 with a summary of the key preliminary findings emerging from the evaluation.

2. Project Overview and Context

This chapter opens with an overview of the Housing First pilot's operational features. This is followed by a description of the context in which the project operates, including details of the welfare entitlements of, and other support services available to, service users.

2.1 Project description

This section provides details of the project's: aims and underlying philosophy; target group; referral, assessment and recruitment protocols; staffing and support arrangements; housing and tenancy type; and policies regarding drug misuse.

2.1.1 Aims and principles

The project's overall aim, as noted in Chapter One, is to reduce re-occurring homelessness by accommodating and supporting individuals who are in active addiction. This is underpinned by a number of specific objectives regarding intended service user outcomes, which TPS define as follows:

- improvement in personal living situation (e.g. move away from street homelessness, sustainment of tenancy etc.);
- reduction, or no increase, in substance misuse (as appropriate to service users' personal goals);
- reduction, or no deterioration, in injecting and associated risk behaviours;
- reduction in involvement with criminal activity;
- improved psychological wellbeing;
- improvement in overall physical health; and
- improved capacity to participate in and be valued by society.

The project is underpinned by the philosophy that if homeless people are provided with the security of their own home, along with adequate support, they will be better positioned to begin a journey toward recovery from addiction.

It is founded on seven key principles. First, service users are provided with *independent accommodation in scatter site housing*, in this case standard housing association (HA) tenancies. Second, the pilot has *no requirements regarding 'housing readiness'*, that is, there are no admission criteria regarding independent living skills, sobriety, or readiness to address an addiction. Third, the project operates a *harm reduction approach* to substance misuse. Fourth, there are *no time limits* on either the length of tenancy or the duration of support provided.

The fifth key principle relates to *respect for consumer choice* regarding levels of engagement with support. Service users are assertively encouraged to meet with a member of staff at least once per week, but the intensity of support is determined on a client-centred basis. Service users are offered a (limited) degree of choice as regards the flat they are allocated, but only insofar as is usually the case for HA lets in Glasgow.

Sixth, *holistic support is available 24/7*. The office is staffed 8am-8pm Monday to Friday and 9am-5:30pm Saturday; a member of staff is on call to deal with emergencies outside these hours.

Finally, TPS aims to target some of the *most vulnerable* members of the homeless population, these being individuals actively involved in substance misuse – a group whom often have difficulty coping with traditional services and/or are resistant to service interventions.

The principles described above accord with those endorsed by Pathways to Housing, the organisation that first developed the Housing First model in the US (see for example Tsemberis and Eisenberg (2000) and Tsemberis et al. (2004)). Some operational features have necessarily been adapted given the UK's very different housing market, service network and welfare regime: the use of social rather than private rented sector housing being an obvious case in point.

2.1.2 Target group

As noted above, the project targets homeless people in Glasgow who are in active addiction and are poorly served by existing service arrangements. Specific eligibility criteria include:

- being aged 18 or older;
- being homeless, that is, 'statutorily homeless' and qualified for a 'Section 5 referral'¹;
- having a current drug, alcohol or poly-substance misuse problem;
- needs are not being met by current services; and
- holding a desire to sustain a tenancy.

2.1.3 Accommodation type and tenure

All service users will be allocated independent scatter-site housing provided by housing associations. The housing will be located in the areas of Glasgow in which each of the seven participating housing associations operate, these being the North, West and Southern regions. Each property is an 'ordinary' self-contained flat, typical of social housing within the city. Service users are given the same (very limited) degree of choice of housing that other housing association tenants are subject to. Service users are provided with a Scottish Secure Tenancy (SST), with rent contract and unlimited lease.

2.1.4 Referral, assessment and recruitment

Referrals for the project can be made from a number of homelessness, addiction and allied support agencies, or via self-referral. All potential service users then undergo a period of assessment

¹ The UK, including Scotland, has a 'statutory homelessness system' whereby specific households 'accepted' by local authorities as homeless are entitled to be rehoused in 'settled' accommodation. While in most instances these households are rehoused in the local authority's own accommodation, in Scotland only there is also a duty on housing associations to rehouse statutorily homeless households referred to them by local authorities (this duty was enacted under Section 5 of the Housing (Scotland) Act 2001, hence the term 'Section 5 referral'). Housing associations are only permitted to refuse these referrals in very limited circumstances and the expectation is that they will normally rehouse referred households within six weeks. In Glasgow's case these Section 5 provisions are especially important because, in March 2003, all of the City Council's housing stock was transferred to the Glasgow Housing Association (GHA). This means that the local authority relies entirely on GHA and other housing associations in the city to rehouse those households to whom it has a statutory homelessness duty.

wherein their support needs are assessed (with a view to developing a client-centred support plan), as is their motivation to maintain a tenancy (as per the eligibility criteria specified above).

Referrals are then evaluated by an 'allocations group', comprising TPS staff, an Occupational Therapist, and representatives of the Glasgow City Council housing casework team. Once service users are formally recruited to the project, Section 5 referrals are forwarded to housing providers (see footnote 1 above).

2.1.5 Staffing and support

The project's staff team consists of a service co-ordinator, two assistant service co-ordinators, and four peer support workers. All are employed full-time. The service coordinators carry out service user assessments and visits, and line manage the peer support workers.

The peer support workers, whom have histories of homelessness and substance misuse, deliver most of the day-to-day support to service users (although the service coordinator and assistant service co-ordinators are also actively involved in frontline support delivery). In terms of staff: client ratios, peer support workers each have four to five clients each. A member of staff is on-call to deal with emergencies outside office hours.

Assertive outreach and motivational interviewing techniques are used, and staff are highly flexible in terms of when, where and how they engage with service users. Support plans are developed on a client-centred basis, and staff assist service users to access any other services they need (e.g. health care, drug/alcohol treatment, welfare benefits, education/training etc.)

2.1.6 Policies re drug use

Liaison between TPS and Strathclyde Police, prompted in large part by concerns expressed by housing providers regarding their legal obligations when accommodating people known to be involved in active substance misuse (see Chapter 6), led to the development of a working protocol regarding drug misuse. Key elements of TPS's policy on drug misuse thus include the following stipulations: service users must not allow another person to use substances in their flat; drug paraphernalia should not be visible to staff when they visit service users in their home; staff must inform the police if they suspect service users are involved in dealing; and any illicit substances seen by staff should be surrendered by service users and taken straight to a Police station by staff.

2.2 Project context

The pilot's service users, along with other homeless and vulnerable groups in the UK, are eligible for a range of financial and other forms of support. All users of Housing First will have access to an income maintenance (i.e. subsistence) benefit if they are unemployed or if, as is more often the case, they are assessed as sick or disabled. The key benefits are Jobseekers Allowance (JSA) (for those who are unemployed) and Incapacity Benefit (IB) or Employment Support Allowance (ESA) (for those who are assessed as sick or disabled). It is also possible for some Housing First clients to claim Income Support (IS) if they are on a low income but are not required to be available for work for reasons other than sickness or disability (i.e. they are a lone parent with at least one child aged under seven years).

The qualifying conditions vary depending on which of these income maintenance benefits is relevant, but in all cases the level of conditionality attached to receipt of benefit has increased in recent years. In respect to JSA, applicants must be available for and actively seeking work, and there are also now specific requirements to participate in the UK Work Programme, with the possibility of benefit sanctions (i.e. time specific benefit reductions, for up to three years) if claimants fail to meet these conditions. With respect to IB and ESA, claimants must 'pass' unfitness for work tests, which have become more stringent in recent years, with a national programme underway to review all sickness and disability benefit claims with a view to removing some claimants from benefits altogether or moving them onto JSA. There are also now some requirements on recipients of these sickness and disability benefits, and on lone parents receiving IS, to participate in 'work-related activity' with the possibility of benefit sanctions if they fail to do so.

In general, there is no time limit on receipt of any of these benefits, so long as the claimant continues to meet the qualifying conditions. However, that may change in the future as both major political parties are actively debating the introduction of time-limited unemployment benefits and the public seem sympathetic to this idea.

The level of income provided by JSA and IS is very low as compared with the replacement ratios found in other northern European countries for those who lose their jobs. Benefit levels are somewhat more generous in the sickness and disability benefits (i.e. in ESA and IB) but it is still highly debatable whether they provide a decent minimum for those who have no other source of income (as will be the case for almost all Housing First clients). All of these benefits are subject to the recently announced 1% cap on benefit uprating in UK; meaning that the real value of these (already very low) income maintenance will fall over the next few years.

Traditionally, the very low levels of income maintenance benefits in the UK have been mitigated to some extent by relatively generous housing allowances provided under the Housing Benefit (HB) system for tenants in both the private and social rented sectors. However, there are now very significant cuts being made to this HB system as part of the current UK Government's radical welfare reform agenda. Most of the HB cuts so far affect private tenants and it is still the case that the majority of out-of-work claimants in the social rented sector (where all current Housing First clients are accommodated) will be entitled to have 100% of their rent met by HB. HB for social tenants may be reduced in some specific instances, such as when there is a 'non-dependant' living in the household who is assumed to make a contribution to the rent. Potentially more relevant for Housing First clients, however, is the 'bedroom tax' being introduced from April 2013, whereby social tenants across the UK will face reductions in their HB allowance if they occupy a property deemed 'too large' for the size of their household. Given the mismatch between the Scottish social housing stock (mainly family sized) and demand for social housing (mainly single people, especially single men) some 90,000 social tenants in Scotland are expected to be affected by the bedroom tax, including possibly some Housing First clients

Job prospects for Housing First clients are extremely limited. Most have severe labour market 'disabilities' associated with their myriad physical and mental health problems, often closely related to their substance misuse. These are often compounded where service users have criminal records. The demand for labour in Glasgow is in any case very weak as compared with more prosperous parts of Scotland and the wider UK, with high levels of long-term unemployment concentrated in large areas of multiple deprivation. There are a range of programmes available in Glasgow and elsewhere in Scotland to link homeless people with labour market opportunities, but the prospects of success have receded with the current economic downturn as more qualified candidates are increasingly squeezing the most disadvantaged out of entry level jobs.

A wide array of health care and allied support services is available to the users of Housing First in Glasgow. Some of the key ones used by the project's service users include: general practitioners, specialist mental health services (e.g. psychiatrists, Community Psychiatric Nurses), drug and alcohol treatment services (e.g. detoxification, community or residential rehabilitation), and employability agencies. The project's target group typically have difficulty navigating their way through and meeting the demands of the service 'system'. The Glasgow Housing First pilot was thus designed to support service users to access existing services rather than duplicate them by delivering them in-house (via an Assertive Community Treatment team, for example).

As is typical elsewhere in the UK, there are also a wide range of accommodation and housing-related support services for homeless people in Glasgow but these, unlike Housing First, are typically premised on a 'treatment first' philosophy. Systems dictating how and when an individual might progress from one form of transitional accommodation to another are not as rigidly prescribed as are staircase approaches dominant in many other European countries, but they nevertheless require evidence of 'housing readiness' before accommodating individuals with complex needs in 'normal' independent housing (Johnsen and Teixeira, 2010, 2012).

The Glasgow Housing First pilot is a single project, run by a voluntary sector organisation, testing the effectiveness of the Housing First approach for a specific client group in the UK context. It is not part of a wider (regional or national) strategy. There is evidence that the Housing First approach is beginning to be adopted elsewhere in England and Wales, however (see Chapter 6).

2.3 Conclusion

In summary, the Glasgow Housing First pilot supports 22 homeless people aged 18 or over who are involved in active substance misuse. It aims to accommodate service users in 'normal' independent housing association flats, on a scatter-site basis, with a rent contract and unlimited lease. It is staffed by a team of seven, including four peer support workers who have histories of homelessness and substance misuse. Support plans are developed on a client-centred basis and assertive outreach and motivational techniques are employed by staff. Staff members assist service users to access welfare entitlements and other support services, as appropriate to their client-centred support plan.

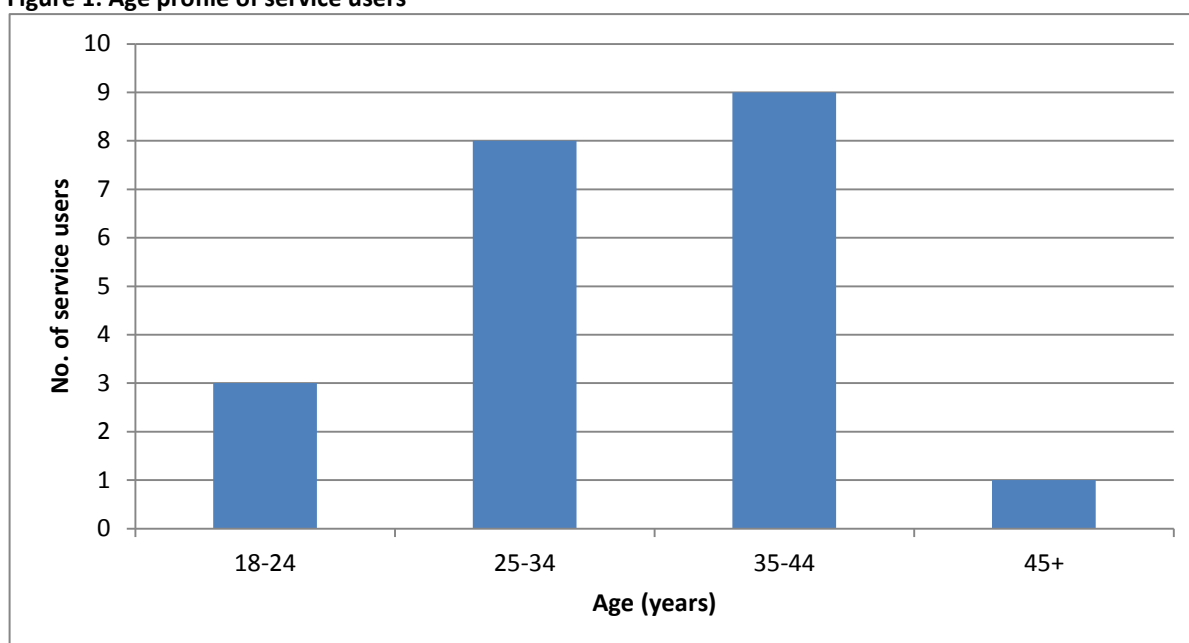
3. Service User Profile

This chapter provides a profile of the service users' characteristics and support needs at the point of recruitment to the pilot. It draws upon wave one ('baseline') service user interviews (see Chapter 1). It begins by describing service users' demographic characteristics, housing circumstances and accommodation histories. It then provides details regarding their health, type and severity of substance misuse, involvement with the criminal justice system, and economic status at the point of recruitment.

3.1 Demographic details

Of the total 22 service users, 18 are male and 4 female. The majority were aged between 25 and 44 years at the point of recruitment, as shown in Figure 1. All are of White British ethnic origin.

Figure 1: Age profile of service users



Source: wave one service user interviews. Base: 21.

All were single person households at the point of recruitment to the pilot. One female service user has since had a baby, and continues to care for the child with the support of Housing First staff and social workers. Several others have children who are in the care of an ex-partner or other relatives.

3.2 Housing histories

At the point of recruitment, most (n=12) service users were living in a hostel or other form of temporary accommodation for homeless people (e.g. a temporary furnished flat). Of the others, 4 were in an addiction rehabilitation facility, 3 were staying temporarily with friends or family because they had no home of their own, and 2 were sleeping rough.

Almost all service users have had long-standing histories of homelessness and insecure housing. For the majority, these experiences began in their mid/late teenage years. Their adult lives have been

punctuated by repeated periods of rough sleeping, sofa-surfing, stays in hostels or other temporary accommodation (such as bed and breakfast hotels), and time spent in prison. As a consequence, many found it impossible to calculate with any degree of accuracy the total number of homelessness episodes experienced or total length of time they had been homeless.

I've been sleeping rough and in jail off and on for 20-odd year. (Male service user, in 40s)

It's been a revolving door: prison, sleeping rough, hostels, since I was 19. (Male service user, in 30s)

Service users' experiences of hostels had been overwhelmingly negative. Many described them as depressing and chaotic environments which were not conducive to addressing substance misuse problems:

There was one [hostel] I stayed in was so bad that I nearly turned around and walked right back out again. There was people smoking heroin on the stair and drinking and I'm like: 'I'm trying to get better but you're putting me into a place like this?' (Male service user, in 30s)

Several had been evicted on multiple occasions for failing to adhere to the rules and regulations of hostels. A few also expressed frustration with having to 'start over' in the city's (linear) response to homelessness after 'making silly mistakes', most of which were directly related to their addiction:

They [the council] would put you in a temporary furnished house while you were waiting for your own place, but then I would go to jail and lose it, and then have to start again. (Male service user, in 40s)

As noted above, some of the service users were staying with friends and family on a temporary basis (i.e. 'sofa-surfing'). Some of these arrangements were very fragile, and as one service user explained, risked exacerbating substance misuse problems:

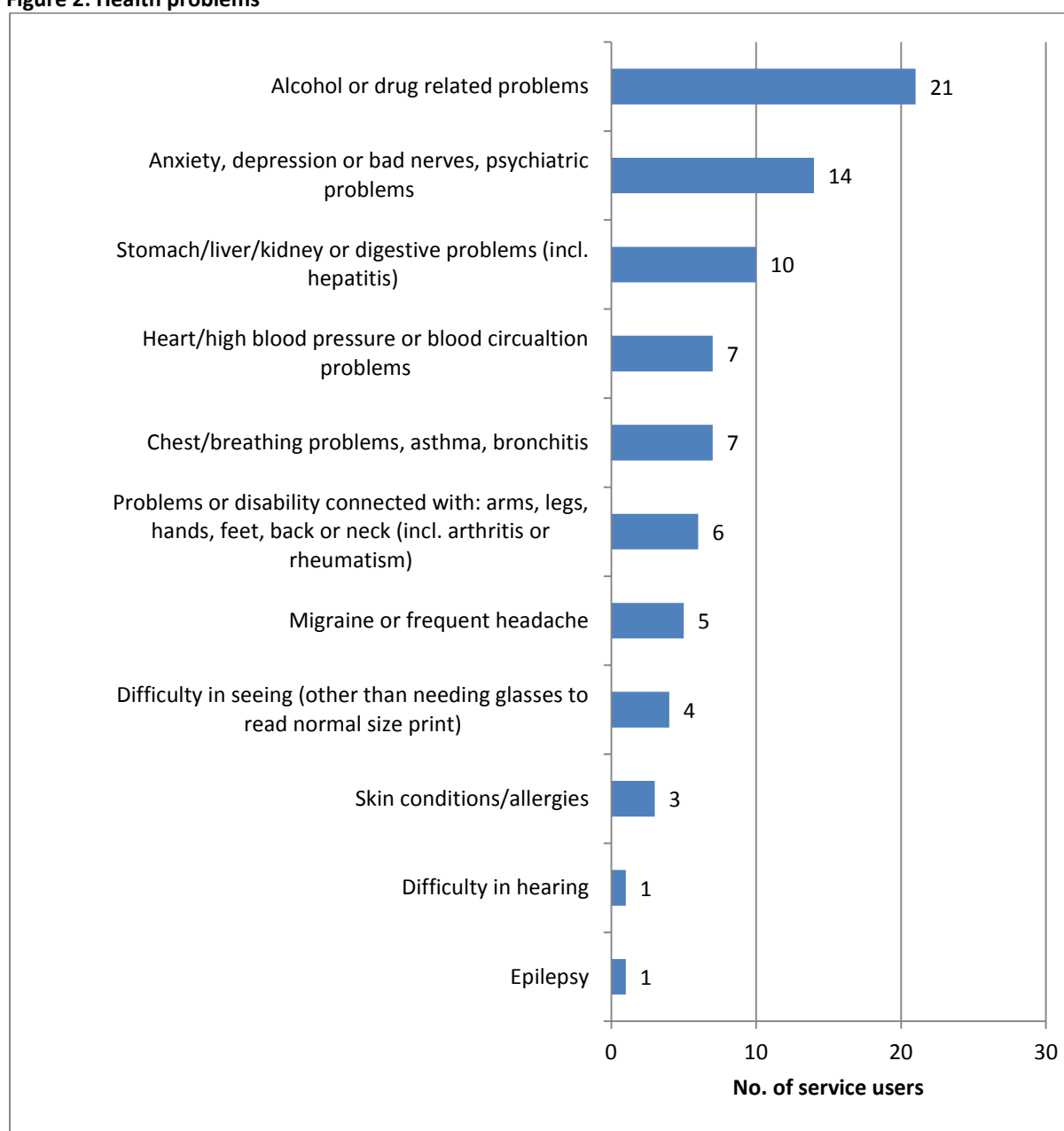
A lot of time I'm worrying about where I'll be staying. If I'm staying with someone who takes heroin, I'll buy them heroin. Or I'll do the same with alcohol if they're drinkers, so I can live in their house. Whatever their preference is, I'll buy for them and end up taking with them just so that I can live there for the night. (Male service user, in 30s)

A total of 12 service users had had their own independent tenancy at some point, the majority of which had been in the social rented sector. The length of time that they had maintained these tenancies varied (from a few weeks to a few years). Reasons for loss of tenancy included: rent arrears, prison sentences, or having been the victim of anti-social behaviour from neighbours or drug-using peers/dealers.

3.3 Health and substance misuse

When asked to assess their overall health at the point of recruitment, 2 service users described it as 'good', 12 as 'fair', 4 as 'bad', and 1 as 'very bad' (none as 'very good'). Figure 2 portrays the (current) health problems service users (self)-reported at point of recruitment. Notably, 14 reported problems relating to mental health. Of these, 12 reported that they had ever been prescribed medication for mental health problems, and 5 that they had been hospitalised for mental health problems (in some instances on multiple occasions).

Figure 2: Health problems



Source: wave one service user interviews. Base: 21. More than one response possible.

Other health problems affecting a notable proportion of service users at the point of recruitment included digestive or liver problems (typically hepatitis) (n=10), and blood circulation problems (often deep vein thrombosis caused by intravenous needle use) (n=7) (Figure 2).

All service users reported having an active drug and/or alcohol problem (an eligibility criterion for recruitment to the pilot). The severity of their addiction at the point of recruitment was assessed with the aid of the Severity of Dependence Scale (SDS)². This confirmed that drug addictions were very severe in a number of cases: scores (for those using drugs in the past month) ranged from 3 to

² The SDS is a validated measure assessing the severity of an individual's addiction to drugs or alcohol. Scores may range from 0 to 15: a score of 3 or higher is generally considered to be indicative of dependence, with higher scores indicating greater severity of dependency (Kaye and Darke, 2002; Lawrinson et al., 2007).

14, with an average (mean) of 9 (notably above the score of 3 which is generally considered to indicate dependency).

SDS scores calculated regarding alcohol dependency were lower, ranging between 0 and 11 (average 3), but indicate that a minority of service users (also) experience relatively severe levels of alcohol dependency. For virtually all, substance misuse problems had begun early in life, in many cases in their early teens.

Table 1 lists the drugs that service users reported having used in the month prior to recruitment to the project. Two thirds (n=14) had used heroin, and 15 had used methadone (on prescription) as a heroin substitute. 12 had used cannabis, and smaller numbers other substances including valium, cocaine, diazepam, crack, speed and ecstasy. 12 had injected drugs (in all instances heroin) in the month before recruitment.

Table 1: Substances consumed in the month prior to recruitment

Substance	No. of service users
Methadone	15
Heroin	14
Cannabis	12
Valium	8
Cocaine	6
Diazepam	5
Crack	2
Speed	1
Ecstasy	1

Source: wave one service user interviews. Base: 21.
More than one response possible.

Many service users emphasised that the frequency and quantity of their drug and/or alcohol consumption fluctuated significantly, sometimes daily, depending on factors such as their state of income and/or mental health:

I would be a binge drinker if I had enough money! [laughs] I drink now and then, but how often and how much depends on how much money I have. (Male service user, in 40s)

I binge but that has a lot to do with how I'm feeling at the time. Sometimes my depression gets a bit much. I just think 'fuck it, fuck everything'. (Male service user, in 20s)

All had had treatment for substance misuse in the past, often including residential rehabilitation (and in a few cases numerous times). Whilst they had typically found this to be effective at the time, most had nevertheless returned to homelessness and substance misuse shortly afterward. Periods of being 'clean' and/or 'dry' were thus generally short-lived.

All but one of the service users with a drug problem aspires to be completely drug free in the medium-to-long term (the one exception has the more limited aim of stabilising drug consumption in the long term). With regard to alcohol, a few aim to be teetotal but a greater number aspire to become 'sociable drinkers', that is, able to drink 'in moderation'. The following comments were illustrative of widely held aims regarding substance misuse:

When it comes to drugs I would like to be abstinent. And when it comes to alcohol I would like to have it under control. When I do drink I would like to be able to say 'that's me, I've had enough, I'll just have four cans and that's it. I'd like to be able to take me da [father] or me brother to the pub and be sociable. (Male service user, in 30s)

I wish I could just drink socially, like at the weekends or something like that ... If I can't become a sociable drinker I'll just need to try and come off the drink ... I just need to settle down man. I just need to stop going from house to house to house to house and getting mad w'it. (Male service user, in 20s)

3.4 Criminal activity

All but two (n=19) service users had had direct involvement with the criminal justice system at some point in the past. Most of their offences had been acquisitive (e.g. shoplifting or car crime), explicitly drug-related (e.g. possession or dealing), breaches of the peace, and/or related to street culture activities (e.g. sex work). A small number had also committed serious violent offences such as serious assault, assault and robbery, and police assault. Most had served multiple sentences:

I've been in and out of prison from the age of 21. My biggest gap without going to prison has been three year, but apart from that I was in at least once a year. Always drugs related, for thieving or selling drugs. Never any assaults or anything like that, it's always been to make money for drugs. (Male service user, in 30s)

More than half (n=12) had been arrested or fined for an offence in the twelve months prior to pilot recruitment. They consistently emphasised that their involvement in criminal activity was directly related to their substance misuse problems, and believed the only way to reduce involvement in criminality was to address their addiction.

3.5 Financial wellbeing

Most service users reported that they found it virtually impossible to manage/budget the limited funds they had given their active substance misuse problems. Some were supplementing their income via (illegal) street culture activities at the point of recruitment.

The financial difficulties of a number were exacerbated by automatic deductions from welfare payments for outstanding loans or fines and/or informal payment of 'debts' owed to drug dealers or fellow users.

Furthermore, a fragile, and damaging, financial co-dependence on fellow drug users/ drinkers was a significant feature in the lives of several service users:

A lot of time I'm worrying about where I'll be staying. If I'm staying with someone who takes heroin, I'll buy them heroin. Or I'll do the same with alcohol if they're drinkers, so I can live in their house. Whatever their preference is, I'll buy for them and end up taking with them just so that I can stay there for the night. (Male service user, in 30s)

3.6 Social relationships

On a related note, many service users reported that their social networks at the time of recruitment to the pilot consisted almost entirely of other people with drug and/or alcohol problems. 'Friendships' were thus described as superficial, and shaped by the co-dependency described above. All acknowledged that their peer networks would need to change profoundly if they are to become, and remain, free from addiction:

Sometimes I sit in people's company that I'd rather not. People that are mean, or violent. I'd rather avoid people like that, but sometimes they are the only ones that'll give me a couch to sleep on. So, you just need to put up with it, which is not very pleasant, because these people can be quite volatile. I've got the scars to prove it, you know what I mean? (Male service user, in 30s)

Several explained that their addiction exacerbated feelings of loneliness and isolation. For example:

I don't really see my family when I'm on drugs and that. I just seem to block myself off ... I don't socialise when I am on drugs, I don't want to do nothing. (Female service user, in 20s)

Family did however provide valuable instrumental and/or emotional support for a number of service users. These individuals all had immediate family (such as parents, siblings or children) living locally, whom they visited regularly (in some instances more than once a week). Others, however, could or would not maintain contact with family members because of estranged relationships, the vulnerabilities of other family members (e.g. addiction or mental health problems), or feelings of shame regarding their own current circumstances:

At the moment I've lost contact with them [sons] because I am here there and everywhere. And it'd be embarrassing. I mean, my son's doing a lot better in life than me, you know what I mean? And I don't want to bring them down and they worry a lot about me. (Male service user in 30s)

Most were however optimistic that gaining a settled home, with support, would help them develop the stability and confidence required to re-establish relationships with family, especially children.

3.7 Employment and meaningful activity

Approximately half (n=10) of the service users had never had long-term (i.e. non-casual) paid employment. The others had had paid jobs in the past, but had not worked and had been reliant on welfare benefits since developing drug and/or alcohol problems.

I've always had a drug problem with spells of depression and not wanted to go anywhere or do anything. I was not mentally or physically able to work. (Male service user, in 30s)

A few found it virtually impossible to think about long term goals regarding employment or training. Of those that felt able to think about the future, all aspired to work in the long term. Most did however consider this to be a very distant goal, given their current state of homelessness, addiction and/or lack of qualifications. Service users' aspirations in this area were often tempered by concerns about their employability given their disabilities, poor health, and/or criminal records.

All service users noted that at the point of recruitment their daily lives lacked meaningful activity. For many (with the obvious exception of those in rehab at the time), daily life revolved around the acquisition and consumption of drugs or alcohol:

My day involves getting up, getting ready, going out and shoplifting to fund my bags of heroin. Then just shoplifting all day to buy drugs 'cause of my drug habit and that. It's not what I want to be but that's the way it is, you know? (Male service user, in 30s)

3.7 Conclusion

This chapter has described the characteristics of the pilot service users at the point of recruitment to the pilot. Most were male, aged between 25 and 44, and all White British. The adulthoods of almost all typify the 'revolving door' of repeat homelessness and institutional care (e.g. prison, rehabilitation, hospital, psychiatric wards etc.). Substance misuse problems dated back to teenage years for most, and addictions were severe in a number of cases (particularly in the case of drug addicts, less so alcoholics).

The majority of service users were struggling to cope financially at the point of recruitment. Most had weak or fragile (and often potentially damaging) social support networks at the point of recruitment, although some benefited from support from family. Boredom and a lack of meaningful activity were significant features of the daily lives of almost all at the time. Virtually all aimed to (re)gain employment or participate in training/education, but these were considered very long-term goals by most. The acquisition of housing and stabilisation of substance misuse problems were consistently accorded higher priority in short- to medium-term goals.

4. Support Provided and Service User Satisfaction

This chapter provides details regarding the duration and type of support provided by the pilot and its engagement with other mainstream services. This is followed by an outline of service users' levels of satisfaction with the support received insofar as data allows at this stage of the evaluation. The chapter draws wave one data, and all wave two data collected to date, this being interviews with 13 service users, 11 stakeholders, and a senior member of the staff team.

4.1 Support received

The support provided by the pilot is not time-limited, and all service users recruited to the pilot are still receiving support from it (with the exception of one who is sadly deceased, see Chapter 5). The degree of engagement of some has fluctuated throughout the pilot period, but to date none has exited the programme. One individual, who has been supported by the project for more than a year, is considering terminating his involvement with Housing First because he has met all his goals and believes that he no longer needs the support provided.

Staff typically meet with service users twice per week, but have in a number of cases reduced this to once per week at the request of service users when they have felt confident to live more independently. Levels of support have been a lot higher in a minority of cases (exceeding five times per week), in most instances for short periods during and/or immediately after an individual has moved into their flat, but also in a few cases when service users were experiencing a 'dip in mood' (see Chapter 5).

In many instances the level of support has not changed at all (in terms of the number of meetings with staff per week), but the nature or focus of support has tended to evolve as service users' goals have altered. Intensive support was often provided with 'making a house a home' via the acquisition of furniture and decorating immediately after moving into a flat. This was often followed by a period supporting individuals to stabilise or reduce their substance misuse. For many, attention was then able to focus on accessing training or other meaningful activities once individuals felt settled in their new home and were successfully 'managing' their addictions. The provision of support has not always followed this pattern, however, given the non-linear nature of the cycle of addiction recovery.

The wave two service user interviews conducted to date indicate that most service users do foresee a time when they will be able to live completely independently without support from the Housing First team. Yet, with the exception of the individual mentioned above who is about to make a planned exit from the programme, none feels able to specify when this is likely to be. Significantly, a number note that the Housing First frontline staff are key to their social support network and fear that they would feel lonely, and thereby vulnerable to relapse, without regular contact from staff.

4.2 Availability of mainstream services

As noted in Chapter 2, there is an expansive range of other mainstream services available to service users in the areas of physical health, mental health, employment and training, debt counselling and related areas. A key objective of the Housing First project is to assist service users to access these. Positive working relationships between frontline staff of Housing First and those of participating agencies has been key to encouraging some to give potential service users a 'chance' by allocating

them housing, particularly where they have a history of failing to adhere to accommodation providers' rules and regulations on multiple occasions.

A number of multi-agency groups have been involved in the project's development and oversight, and this helped foster positive relationships between Housing First and other service providers in Glasgow. Initially, a steering group consisted of 32 individuals representing 13 agencies working in homelessness, housing, health, social care and criminal justice sectors was developed. This was subsequently reconfigured to a smaller and more focussed 'advisory group' comprising ten members representing six key stakeholder agencies.

Day-to-day communication and joint working between agencies is also fostered by inviting relevant representatives (e.g. drug/alcohol treatment care managers or day service key workers) to service users' review meetings, held quarterly, to discuss any barriers or challenges encountered in the delivery of their support plan. Stakeholder interviews indicate that involvement in such meetings is universally welcomed by other support agencies involved in the delivery of service users' care plans.

At the national level, the Scottish Government has publicly expressed its support of the general principles underlying Housing First (Johnsen and Fitzpatrick, 2012). Furthermore, a number of stakeholders emphasised that the pilot complements the Scottish Government's most recent drugs strategy (Scottish Government, 2008), which, whilst focussing less on harm reduction than previous strategies, is firmly based on the broader notion of 'recovery'.

4.3 Service user satisfaction

The data gathered to date indicates that the support provided by the project has, almost without exception, met the needs and preferences of service users. All have developed positive relationships with frontline staff who are widely regarded as being non-judgemental, 'easy to talk to' and trustworthy:

I feel comfortable talking to them [staff] and telling them about the problems I've got. Even asking for help, which sometimes is kind of tough for me ... The staff go above and beyond the call of duty. They've not got caseloads like that they are only just working with you to get another file off their desk. They don't get you somewhere and then just leave you. (Male service user, in 30s)

Notably, the inclusion of peer support workers in the staff team has been widely regarded as a key strength of the project. Their 'shared histories' (of homelessness and substance misuse) have served to break down perceived barriers regarding the potential risks of being 'judged' and enhanced service users' motivation toward recovery:

They've [the staff have] been great. A few of them know where I'm coming from 'cause they've been users themselves. They're not bullshitting you. From my point of view that makes a difference. They've been there, they've done it all ... It gives that wee sense of saying like 'I could do that', you know what I mean? (Male service user, in 30s)

Service users particularly appreciate the flexibility with which the support is delivered, knowing that they can ask for more or less frequent meetings if/when their circumstances change. Wave two interviews conducted to date indicate that service users generally agree that the 'starting point' of holding two meetings per week is 'about right'. They are also reassured by the fact that the support will not automatically end at some pre-determined date and that support may be accessed 24/7. The

user choice element of the project as regards the degree of engagement with support is thus highly valued.

Service users expected that they would have very limited choice with regard to which flat they were provided, given pressure on social housing supply and the way it is allocated. Wave two interviews conducted thus far nevertheless indicate that they are generally satisfied with the type, size and quality of their flat. The majority were also satisfied with the neighbourhood, albeit that one experienced harassment and requested to be moved to a different area (see Chapter 5).

Given the pressure on social housing stock, a number of service users had experienced substantial delays (in some cases of many months) in the allocation of housing. Delays were most acute when service users were very specific about which area they wanted to live in and/or if they changed their mind about where they wanted to live, in the latter case necessitating a new application to a different housing association. Some delays were also incurred when service users were admitted into psychiatric care institutions for sustained periods, in which case they were no longer considered homeless and housing applications had to be withdrawn. Such delays in the allocation of housing had been de-motivating for a number of service users.

Service users also commonly emphasise the value of the project's approach to substance misuse. This, they note, enables them to be 'honest' about their addiction, thereby aiding their journey toward recovery because they do not feel compelled to 'lie' in order to avoid losing their flat during periods of relapse, for example.

The thing is that when you start lying, the whole deceit thing kicks in. You lie for a lie, then have to tell another lie ... Lies kind of roll off my tongue naturally, probably because I've been doing it for so long. But I'm just tired of doing it. The prospect that I can be honest, and just say 'look, I'm too drunk today, or too full of it today', and they won't give up on me ... It's going to help me a lot, just 'cause I don't need to lie anymore.
(Male service user, in 30s)

Overall, the majority of service users interviewed to date reported that they could not praise the support provided highly enough, most particularly given that staff 'never give up', even when service users encounter 'blips' on their journey toward recovery (e.g. relapse and/or temporary disengagement from support). Virtually all have said they would recommend the project to other homeless people actively involved in substance misuse.

4.4 Conclusion

This chapter has noted that all the service users recruited to the project continue to be supported by it, with the exception of one whom is deceased. The intensity and/or nature of support provided by staff has evolved in concert with the changing needs and/or goals of service users. This flexibility is regarded as a key strength of the project by service users. Together with the positive relationships service users have established with staff, the flexibility of service delivery has contributed to very high levels of user satisfaction with the project overall. Service users also emphasise the added value that peer support workers bring to the project; so too the 'realistic' approach to substance misuse which enables them to be honest about any slips on their journey toward recovery. Any dissatisfaction expressed relate almost exclusively to substantial delays in the allocation of flats which has affected a number of service users

5. Preliminary Outcomes

This chapter provides details of preliminary project outcomes, insofar as the data collected at this point in the evaluation allows. It draws upon the wave two data collected to date, this being interviews with: a senior member of the staff team (which provided information relating to all 22 service users recruited to the project), 11 stakeholders, and 13 service users (see Chapter 1). Any statistics provided were correct at the point of data collection in January 2013.

It must be emphasised that because wave two data collection is incomplete, firm conclusions regarding outcomes cannot be provided as yet. Definitive conclusions will be published after completion of the evaluation in autumn 2013. Those caveats aside, the chapter comments on emerging findings regarding service users': housing stability; health; substance misuse; involvement with the criminal justice system and street culture; personal safety; financial wellbeing; social support networks; participation in employment and meaningful activity; and community integration.

5.1 Housing stability

Housing First records indicate that of the 22 service users recruited to the project, 16 have been allocated a tenancy to date. The remaining individuals are in temporary accommodation while they await allocation of a flat.

To date, none of the 16 service users allocated a flat has been evicted. Three have however 'lost' their tenancies due to various circumstances. Of these, two did so because they were imprisoned for longer than 13 weeks, which meant that their rent was no longer able to be covered by Housing Benefit (see Chapter 2)³. The third individual relapsed after being housed and was victimised in their home by other members of the drug-using community. The individual affected requested a move back into supported accommodation, with the support of Housing First, where they re-engaged with treatment services. The individual concerned is now abstinent from illicit drugs and looking forward to being allocated a new flat in a different area.

Staff report that of the 16 individuals housed independently with the support of the Housing First project, 13 have maintained their tenancy for at least twelve months; the other three have been living (or lived) in their flat for less than one year.

The project is already widely regarded as a 'success' by other stakeholders in Glasgow, given the rate of tenancy sustainment achieved thus far. Several service providers in the city emphasised that they had not anticipated such positive housing outcomes, particularly given the 'chaotic' histories of many of the service users recruited.

5.2 Health

For the majority of service users, general health has improved, in some cases dramatically. Improvements in physical health are generally attributed to the reduction or cessation in illicit substance use and/or reduced alcohol consumption (see below), but also to improvements in diet.

³ Of the two individuals losing their tenancies because they received a prison sentence of longer than 13 weeks, one is still serving their sentence, and the other tragically experienced a fatal overdose upon release from prison.

Some individuals, nevertheless, are still in poor health and require substantial health care interventions from mainstream services such as general practitioners, dentists and/or hospitals.

Preliminary data indicates that the overall direction of change with regard to mental health is also one of improvement. Staff observe that the mental health of service users who have been housed in an independent tenancy is generally better than those who are still in temporary accommodation. Service users report that the security of having stable housing and 'stickability' of Housing First support – which does not terminate should they relapse and/or disengage temporarily – has contributed to enhanced feelings of psychological wellbeing and self-confidence.

That said, a number of service users have experienced what staff describe as a 'dip in mood' after being housed. This is often attributed to feelings of isolation, which have sometimes coincided with delays in acquiring furniture to turn their flat into a 'home'. For some individuals, periods of 'low mood' have been relatively short-lived as they adjusted to independent living. For others, they have been recurrent, triggered by stressors such as welfare benefit payment problems, anxieties about finances, or arguments with friends or family. Deteriorations in mental health have often coincided with an increase in (or relapse into) substance misuse (see below).

5.3 Substance misuse

At this stage in the evaluation, substance misuse outcomes are mixed, but positive on balance. Significantly, given the overall severity of addictions at the point of recruitment (see Chapter 3), staff records indicate that seven of the total 22 service users are now abstinent from both illicit drugs⁴ and alcohol. A further three are now abstinent from drugs (where drugs had been their main substance of choice at the point of recruitment), and another two abstinent from alcohol (where alcohol had been their main substance of choice at that point).

A number of others have continued to misuse drugs or alcohol, albeit often to a lesser degree than before. Some, for example, are no longer using heroin, but smoke cannabis or drink fairly regularly. In such cases, they often report that boredom is a contributing factor to their ongoing drug use and/or alcohol consumption.

Staff report that whilst the overall frequency of drinking and volume of alcohol consumed has reduced for some service users, a number are still drinking at problematic levels. Where particular concerns exist, staff encourage service users to drink less harmful forms of alcohol (e.g. lager rather than what is commonly referred to as 'gut rot' cider) in accordance with a harm minimisation approach. Harm minimisation techniques are similarly employed with those who continue to misuse drugs.

As noted above, some service users relapsed after a period of abstinence or stabilisation. A few have noted that relapses have in large part been caused by 'unwise' decisions regarding who to allow to stay in their flat. Issues relating to difficulties of 'managing the door' are reported to have been far less problematic than had been anticipated by staff and stakeholders, however (see below).

Preliminary data indicate that the majority of service users, including those who have experienced one or more relapses, feel that they are closer to meeting their goals regarding substance misuse than they were at the point of recruitment to the project. They note that secure housing and ongoing support provides them with stability to maximise their chances of 'getting back on track' on

⁴ Most of these individuals are taking prescribed methadone.

their journey toward recovery. Returning to street homelessness or hostels, they argue, would make it very difficult to do so in the short term.

5.4 Involvement with the criminal justice system and street culture

Preliminary data indicates that service users' involvement in criminal activity has reduced in concert with reductions in levels of illicit drug use. A number have however been affected by outstanding warrants, and some have served prison sentences (in most instances for offences committed prior to their involvement with Housing First), since recruitment to the project. Comprehensive data regarding service users' levels of involvement with the criminal justice system will be provided at the conclusion of the evaluation.

Evidence collated to date indicates that levels of participation in street culture activities have undergone similar reductions. For example, whilst five of the total 22 service users were known to beg regularly at the point of recruitment to the project, staff report that this figure has reduced to three. In a similar vein, whilst two service users used to be involved in street-based sex work, none are at present. This outcome has contributed to a marked improvement in service users' levels of personal safety, as described below.

5.5 Personal safety

Staff and service users report that levels of personal safety have been dramatically improved for the majority of service users. A reduction in injecting behaviours and/or the volume and frequency of alcohol consumption have been key contributors to this, as has reduced participation in street culture activities for a number (see above).

With the notable exception of the service user who was harassed in their flat (see above), service users report that they feel safe in their home and neighbourhood.

5.6 Financial wellbeing

Most of the service users participating in wave two interviews to date report that their level of financial wellbeing has improved since becoming involved with the pilot. This improvement is, for the most part, attributed to the fact that much less (or none) of their income is now expended on illicit drugs.

That said, the majority are still finding it difficult to cope financially on their low incomes, given the need to pay for utilities (e.g. gas and/or electricity) and food. Some are also paying off previous rent arrears or other debts, thus placing an additional strain on already limited financial resources.

Assistance with budgeting has been an aspect of support that many service users particularly value. Some have elected to have pre-pay gas or electric meters installed, so that they do not accrue vast utility bills which they are then unable to pay.

5.7 Social support networks

As noted in Chapter 3, a number of service users have regular contact with relatives living in Glasgow, and these family members have generally provided important sources of emotional and instrumental support. Furthermore, staff report that five service users have re-established contact with estranged children, or established contact with them for the first time, since being recruited to the pilot. The prospect of (re)developing such relationships has been an important factor motivating positive behaviour change for the individuals involved.

Some service users have effectively cut ties with former friendship networks since being housed, as they felt this was necessary for them to become and/or remain free of addiction (see Chapter 3). Many of these individuals had requested to be housed a long distance from the areas they used to spend most of their time. They have been particularly vulnerable to feelings of social isolation and/or loneliness since being housed, especially if they do not benefit from the support of family. In such cases, Housing First staff are regarded crucial members of their social support network, most notably as sources of emotional support.

A number of service users are however still in contact with former drug-using peers. They are less likely to report being lonely than the individuals described above, but are more susceptible to relapse. Some of these individuals have found 'managing their door' very difficult, especially where they have felt obliged to 'return favours' to acquaintances who had previously allowed them to stay when they were homeless. The support of staff has been crucial in helping a number of service users address these issues, especially where damaging forms of co-dependency are involved.

5.8 Employment and meaningful activity

As noted in Chapter 3, at the beginning of the pilot most service users anticipated that participation in meaningful activities and having a structure to their day would be key to helping them overcome addiction. Staff report that supporting service users to achieve this goal has been challenging because of the effects of substance misuse on their behaviour and motivation; so too their very low levels of self-confidence. They note that assisting service users to take 'small steps' has been a valuable strategy in helping several individuals develop the confidence and skills required to re-engage with education/training, for example.

Despite such challenges, a number of service users are now successfully involved in meaningful activities. Staff report that at this point in time: five are participating in education or training (e.g. part-time confidence-building or employability preparation courses); five are regularly attending day services (e.g. Narcotics Anonymous or other community-based addiction programmes); two are involved in voluntary work; and two are actively seeking paid employment. Wave two interviews conducted to date indicate that the majority of service users continue to regard the acquisition of paid employment as a long-term goal: something they aspire to but feel they will not be equipped to cope with for a long time (see Chapter 3).

5.9 Community integration

Staff foster opportunities for service users to become familiar with facilities and services in their local neighbourhood where possible, by for example meeting in local cafes, visiting the library, joining a local gym, or encouraging them to access community addiction treatment programmes locally. They do nevertheless emphasise that the norms governing social interactions in such settings are not always familiar to service users, especially if almost all their previous adult 'friendships' have revolved around substance misuse.

Wave two service user interviews conducted to date indicate that many know at least some of their neighbours 'well enough to say hello to'. A few have befriended neighbours, and meet with them fairly regularly to watch television or share meals, for example. Others report that they do not know their neighbours and/or tend to 'keep themselves to themselves' (as would be true for many members of the British public generally).

Instances of neighbourhood disturbance have been very rare. One service user was, as noted above, harassed by former drug-using peers and subsequently moved back into supported accommodation (at her request). That case excepted, housing providers report that their initial anxieties about the risk of service users being involved in antisocial behaviour (as either victims or perpetrators) had not been borne out in practice. A small number of specific incidents had led to neighbour complaints, but in each case a constructive resolution was found without resorting to eviction. In this process Housing First staff acted as intermediaries whom liaised with relevant parties – service users, neighbours, housing providers, and (where relevant) the police – to work toward a constructive resolution.

5.10 Conclusion

At this point in the evaluation, preliminary outcomes look very promising. All but three of the 16 service users who have been housed independently have retained their tenancy; most of these individuals have now been living in their flat for more than a year. The pilot is already widely regarded as a 'success' by other service providers in Glasgow as a result. The vast majority of service users report that they feel safe in their home and neighbourhood, and instances of neighbourhood disturbance have been very rare.

The general direction of change in terms of health has been one of improvement, with a number experiencing vast improvements in physical health. Some service users do however suffer from ongoing physical health issues and a number from periodic fluctuations in mental health. Deteriorations in mental health have often been reflected in increases in substance misuse or relapse.

Several service users have however achieved abstinence from whatever their primary 'substance of choice' had been at the point they were recruited to the project. Notably, those who have slipped on their journey toward recovery report being closer to meeting their goals regarding substance misuse than they were before becoming involved with Housing First.

Involvement with the criminal justice system and levels of participation in street culture activities (e.g. begging or sex work) have declined in concert with reductions in levels of illicit drug use. Periods of incarceration – often for offences committed prior to recruitment to the pilot – have been very disruptive to service delivery and have led to the loss of two (of the total three) tenancies lost to date.

Levels of personal safety have dramatically improved for the vast majority of service users, but one was a victim of harassment in their flat and has subsequently been moved (at their request) back into transitional supported accommodation. Service users' financial wellbeing has improved overall, largely due to reductions in the amount spent on illicit drugs, but most continue to struggle to cope financially on low incomes.

A number of service users have benefited from family support, but feelings of social isolation have been a common experience for others, especially those who have cut ties with former drug- or alcohol-related peer networks. Housing First staff play a pivotal role as sources of social and emotional support in such cases. A number of service users are now involved in meaningful activities such as education/training or voluntary work. Participation in paid work nevertheless remains a long-term goal for most.

6. Lessons Learned and Operational Challenges

This chapter provides an account of the key lessons learned during the development and implementation of the pilot to date. It draws upon all wave one data, together with the 13 wave two service user interviews conducted to date; so too the 11 wave two stakeholder interviews and the interview recently conducted with a senior member of staff (see Chapter 1). The chapter begins by commenting, insofar as preliminary data allows, on the different ‘trajectories’ of service user experiences and outcomes for different subgroups. This is followed by a review of challenges and barriers encountered during project operation and responses to these. The chapter concludes with a brief account of TPS’s plans for the future expansion of Housing First in Scotland.

6.1 Trajectories of experience

Staff report that service users have typically followed one of three general trajectories with regard to the overall direction and/or extent of behaviour change; so too ‘distance travelled’ on their journey toward recovery from substance misuse. These may be described as follows:

1. *Sustained positive change.* For most service users, outcomes have been largely or uniformly positive overall and have, on the whole, been sustained thus far. Generally speaking, their substance misuse has stabilised or reduced (and in some cases ceased), their physical and mental health has improved, any prior involvement in criminal or street-culture activity has terminated, social support networks have strengthened, and they have become increasingly engaged in meaningful activities within the community. Some report having experienced ‘difficult’ periods – experiencing the dip in mood described in Chapter 5 for example – but the general trajectory of their experience has been one of positive lifestyle change and enhanced wellbeing.
2. *Fluctuating experiences.* For this (smaller) group, the overall pattern of experiences could be described as ‘up and down’, in that periods of relative stability or improvement have been punctuated by slips on their journey toward recovery. Symptomatic of such ‘blips’ have been increased levels of substance misuse (usually temporary) and/or deteriorations in mental health. These experiences have often had a knock-on effect on service users’ ability to manage their home, particularly (dis)inclination to budget and/or ‘manage the door’. It is sometimes also reflected in re-engagement with street culture activities. Staff support service users to get ‘back on track’ to meet their goals during such periods, often increasing the frequency of contact in so doing.
3. *Little observable change.* For a small minority of service users, the project has provided housing stability, which they greatly value, but there has (as yet) been little evidence of change with regard to most other outcomes. The individuals concerned are generally still misusing substances at or near to the same level they were before being recruited to the project and/or continue to be actively involved in street-culture activities (e.g. begging). Managing their home (e.g. budgeting, cleaning) continues to present an ongoing challenge. Engagement is sometimes intermittent, but staff report that the security provided by the project means that these individuals are now more receptive to supportive interventions (e.g. health care).

Further details regarding the characteristics of each of these (and/or other possible) trajectories, including the number of service users following each, will be provided at the conclusion of the full evaluation period.

Staff confirm that the characteristics of the individuals following each of the trajectories described above are varied. Notably, there does not appear to be any observable differences between the outcomes of the project for male and female service users, nor those within younger (under 25) or older (over 25) age brackets. In any case, the numbers of women and young people within the project's clientele are too small to allow for the robust comparison of outcomes for different demographic groups.

That said, staff note that the existence of family and/or other support networks does appear to act as a positive, and in some cases powerful, motivating ('protective') factor for some service users. As noted in Chapter 5, a few have begun to (re)establish relationships with estranged family members, including children; this has been deemed an influential motivator in their journey toward recovery.

Similarly, staff report that the service users who are 'doing best' in their flat tend to be those who are also engaged in activities in their community (e.g. community rehabilitation services, training courses, voluntary work etc.). Those whose social networks continue to consist predominantly (or entirely) of substance misusing peers and/or for whom daily activities revolve around the acquisition and use of substances typically find it far more difficult to progress in terms of their recovery.

Staff also note that some (but not all) of the 'highest risk' individuals taken on at the project's outset, notably those with especially long histories of 'entrenched' rough sleeping and involvement in street culture, remain the 'highest risk' at this point in the pilot. These individuals are predominant amongst those following the third trajectory of experiences described above. The staff do nevertheless emphasise the benefit of stable housing, and flexible support, in improving their personal safety and facilitating their engagement with supportive interventions.

6.2 Operational barriers and challenges

A number of key obstacles had to be overcome in order for the project to become operational, and other barriers encountered subsequently. Each is described below.

Firstly, a key challenge involved addressing initial concerns about the 'risks' involved in accommodating people involved in active drug misuse. Housing providers in particular reported having had a number of concerns about their obligations under Section 8 of the UK's The Misuse of Drugs Act 1971. As noted above, such anxieties were nevertheless alleviated via liaison between TPS and Strathclyde Police. This process clarified that whilst it is an offence for service providers/managers to 'knowingly permit' drug misuse on their premises, they are not expected to 'police' them, but rather to respond to any incidents in an appropriate manner (see above for details of the drug use policy adopted).

Secondly, with regard to service user recruitment, those involved in the referral process noted that many service users had initially not understood the potential differences between Housing First and other services, but that this was changing over time as the project became better known:

*I think initially people [potential service users] were just sort of saying, 'Och, we've tried all this', thinking it's going to be a hostel like type thing ... So I think initially they were quite, quite dubious about it. But now they know people that have done all right and the word, the word's out there and they know it's doing quite well, and that it supports.
(Stakeholder)*

Thirdly, staff reported encountering some difficulty recruiting young people to the project – partly because other service providers believed that young people prefer communal supported housing, and/or would not cope in independent accommodation. Some were also reluctant to refer young people with active, but less severe, substance misuse problems.

Fourth, one of the most significant problems encountered has related to delays in the accessing flats once service users had been formally recruited to the project. The co-incidence of this phase in the project with ‘Second Stage Transfer’⁵ of Glasgow Housing Association stock meant that the availability of properties was lower than originally anticipated, and lengthy delays were encountered in the allocation of flats to service users. This has had a detrimental impact on some service users’ levels of motivation (see Chapter 4).

Fifth, delays were also experienced in the acquisition of furniture. TPS had initially planned to get furniture from a local furniture recycling scheme, but a reduction in public donations to the scheme meant that supply was insufficient to meet need. Further, Community Care Grants are not accessible to all service users, and could not be applied for quickly enough to furnish flats before service users moved in. Staff emphasise that acquiring furniture and furnishings at a very early stage so as to expedite the process of ‘making a house a home’ has a positive influence on the rate with which service users feel settled in their accommodation.

Sixth, staff highlighted the challenges in maintaining some service users’ engagement with the support offered by Housing First, particularly once they have been allocated a flat. They had found the relaxation of expectations about the frequency of meetings, whilst persistently ‘being there’, an effective strategy. Frequent contact was maintained with service users insofar as possible during such periods, via telephone calls, text messages and so on.

A further, seventh, challenge related to the imprisonment of service users, usually for offences committed prior to their recruitment to the project (see Chapter 5). Housing Benefit rules enable individuals with sentences of less than 13 weeks to retain their tenancy; but those with longer sentences will lose it. The project continues to support individuals if they do receive a longer sentence and thus lose their tenancy, but staff must begin the (sometimes lengthy) application for housing once again when the service user is liberated from prison.

Levels of buy-in to the project by stakeholders within the homelessness and substance misuse sectors are generally high at management level, given stakeholders’ recognition that, should it prove to be effective, the project has the potential to meet the needs of a group that has to date been poorly served by existing services. This has not ‘trickled down’ consistently to the frontline staff of other agencies, particularly housing associations, however. The anxieties of frontline staff of other agencies have been founded, in part, on a lack of understanding of the Housing First model’s key principles, but also fears that they might be considered ‘responsible’ should Housing First service users cause disturbances within their neighbourhood, for example. Such concerns have diminished substantially as the pilot’s positive housing retention outcomes are becoming increasingly evident.

⁵ ‘Second Stage Transfer’ relates to a process whereby Glasgow Housing Association (GHA) tenants can vote on whether they want ownership of their homes to transfer from GHA to local community-based housing associations. The Second Stage Transfer programme was completed in summer 2011 and saw nearly 19,000 homes transfer in total, after tenant ballots. This complex process has proved challenging for many housing providers in the city and the partners who work with them.

6.3 Future plans

TPS is looking to develop a Housing First project in another local authority area within Scotland. This will support homeless individuals (and possibly families) with a range of needs. TPS also has plans to develop future projects in Glasgow based on Housing First principles, including:

- inclusion of people whose primary support needs are related to mental health; and
- development of a 'Housing Plus' project which provides the same type and intensity of support to people *at risk* of homelessness (i.e. in a preventative capacity).

Evidence suggests that levels of interest in the Housing First approach are increasing in England and Wales. TPS is regularly approached by other voluntary sector providers and statutory commissioners interested in piloting schemes based to at least some extent on Housing First principles. One of these, a project in London developed by Single Homeless Project (SHP), is currently being evaluated by the University of York.

6.4 Conclusion

This chapter has noted that the experiences of service users has tended to follow one of three different trajectories: one characterised by sustained positive change across a range of outcomes; a second defined by fluctuations in mental health and substance misuse in particular; and a third wherein housing has been retained but there have as yet been few discernible changes with regard to other outcomes, improved personal safety and enhanced receptivity to support excepted.

Staff emphasise that it is not possible to identify any demographic characteristics influencing the effectiveness of the project with different subgroups, but note that the existence of family support (and particularly the prospect of (re)establishing contact with children) acts as a positive motivating factor, as does active involvement in meaningful activities within the community.

A number of operational barriers and challenges have been encountered and responded to. These have included: concerns about the risks and legal duties involved in accommodating people involved in active drug misuse; misunderstandings about the differences between Housing First and other homelessness services; difficulties recruiting young people to the project; delays accessing flats and consequent loss of motivation amongst affected service users; delays accessing furniture; difficulties maintaining some service users' engagement with support; the imprisonment of some service users; and stakeholder fears about where responsibilities would lie if neighbourhood disturbances occur.

7. Conclusion

The Glasgow Housing First pilot, which supports 22 homeless individuals with active substance misuse problems, has been operational since October 2011 and will run until September 2013. Conclusions regarding preliminary outcomes must necessarily be tentative at this point in time given that the pilot and evaluation are still ongoing. Indications regarding effectiveness at this point are very positive, however, especially given that almost all of the project's service users are highly vulnerable, with long histories of repeat homelessness, institutional care and substance misuse problems (some of which were severe at the point of recruitment).

At this stage, housing retention rates appear to be high and the pilot is already widely regarded as a 'success' by stakeholders in the city as a consequence. Incidences of neighbourhood disturbance have been rare, and certainly far less prevalent and/or problematic than had been anticipated by many other service providers. To date no such cases have led to eviction due, in large part, to the valuable intermediary role Housing First staff have played in developing constructive resolutions to any neighbour complaints or conflicts.

The health of most service users has improved, albeit that some still experience physical health problems and/or fluctuations in mental health. Substance misuse outcomes are mixed, but positive on balance, particularly given that some service users have achieved abstinence from their former primary 'substance of choice'. Reductions in involvement with the criminal justice system and/or street culture activities largely reflect reductions in overall levels of substance misuse.

The financial wellbeing of service users has improved on the whole, but many still struggle to cope on low incomes. Some enjoy regular contact with family, but others report feeling socially isolated, especially if they have cut ties with former substance misusing peer networks. In such cases Housing First staff play a pivotal and ongoing role as sources of emotional support. A number of service users are now engaging in meaningful activities such as education/training or voluntary work, but involvement in paid work remains a long-term goal for most.

The extent and type of behaviour changes experienced by service users, especially regarding 'distance travelled' on their journey toward recovery, has varied. Data collected thus far suggests that they have tended to follow one of three different trajectories: one characterised by sustained positive change across a range of outcomes; a second defined by fluctuations in mental health and substance misuse in particular; and a third wherein housing has been retained but there are as yet few easily observable changes with regard to other outcomes, improved personal safety and enhanced receptivity to support excepted. There are no clear patterns with regard to the characteristics of the service users experiencing each of these trajectories.

Levels of service user satisfaction with the project are very high overall. All service users have developed positive relationships with frontline staff. The flexibility and 'stickability' of support is highly valued, as is the 'realistic' approach to substance misuse which enables service users to be 'honest' about their experiences on their journey toward recovery. Any dissatisfaction with the project has tended to relate to delays in accessing housing experienced by a number of service users, reflective of current high demand for social housing.

The pilot has experienced a number of challenges since its inception: some of which have related to attitudes (e.g. stakeholder anxieties about the risks involved in accommodating people involved in active drug misuse); others have been more pragmatic (e.g. difficulties acquiring flats and furniture). Other ongoing challenges include: dealing with the incarceration of service users, especially where

sentences are lengthy; mitigating the 'dips in mood' experienced by some service users after they are housed; finding ways to alleviate the social isolation reported by some, particularly those who are trying to avoid contact with former peer networks; continuing to develop ways to support service users to make the (sometimes intimidating) steps toward (re)engaging with meaningful activities; and devising ways to improve outcomes for the minority of service users following the third trajectory of experience described above.

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